

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 455111
30M REV. 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
<div style="display: flex; justify-content: space-between;"> 08931 CERTIFICATE OF DEATH 08923 </div>											
1. DECEASED-NAME (Type or print) EDNA AGATHA CONNOLLY						2a. DATE OF DEATH Month JUNE Day 17 Year 1969			2b. HOUR 9:15 M M		
3. SEX F		4. RACE W		5. DATE OF BIRTH MAR 1, 1885		6. AGE (In years lost birthday) 84 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN 0	
7a. BIRTHPLACE (State or foreign country) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH QUEEN ANNE Md.					
10. CITY OR TOWN OF DEATH CHURCH HILL			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give Street address) COLONIAL ARMS REST			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) AT HOME			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD COUNTY QUEEN ANNE			13c. CITY OR TOWN RIDGELY		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER				
14. FATHER'S NAME First HENRY Middle RHODES Last LYNCH				15. MOTHER'S MAIDEN NAME First ELIZABETH Middle LYNCH Last LYNCH							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no of unknown? NO (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.		17. INFORMANT WILLIAM CONNOLLY Address RIDGELY MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic congestive heart failure 441.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis and aneurysm of the aorta DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Carcinoma of the rectum & colon											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from sec , 19 69 , to June , 19 69 , that (I) (we) last saw the deceased alive on June 7 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Kurt Lederer						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED June 18, 1969			
22d. PHYSICIAN'S NAME (Type) Kurt Lederer, M.D.						22e. ADDRESS Queen Anne, Maryland 21657					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE JUNE 20, 1969		23c. NAME OF CEMETERY OR CREMATORY ST. JOSEPH'S		23d. LOCATION (City or Town) (County) (State) CORDOVA TAL. MD.					
24. FUNERAL DIRECTOR CHARLES V. MOORE, DENTON						25a. REC'D BY REGISTRAR JUN 24 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1519

2

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08932

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

08924

1. DECEASED-NAME (Type or print) First Middle Last Harvey A. Jackson			2a. DATE OF DEATH Month Day Year June 13 1969		2b. HOUR 3:30 PM
3. SEX Male	4. RACE White	5. DATE OF BIRTH December 11, 1876		6. AGE (In years last birthday) 92 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Del.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Queen Anne's Md.		
10. CITY OR TOWN OF DEATH Rural Millington	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ----	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Ret. Farmer		12b. KIND OF BUSINESS OR INDUSTRY Farming	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY Queen Anne's	13c. CITY OR TOWN Millington	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER -----	
14. FATHER'S NAME First Middle Last Andrew Jackson		15. MOTHER'S MAIDEN NAME First Middle Last Frances Ann Cahall			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No.		16b. SOCIAL SECURITY NO. 215-38-0305		17. INFORMANT Address Rural Mrs. Julia H. Jackson, Millington, Md. 21651	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute heart failure DUE TO, OR AS A CONSEQUENCE OF (b) foundice DUE TO, OR AS A CONSEQUENCE OF (c) Cancer of stomach and liver. CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1519					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 7 days 1 yr.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from Apr. 15, 1969 , to June 13, 1969 , that (I) (we) last saw the deceased alive on June 13, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Geza Koralewski		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED June 14, 69	
22d. PHYSICIAN'S NAME (Type) Geza Koralewski, M.D.		22e. ADDRESS Millington, Md. 21651			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE June 16, 1969	23c. NAME OF CEMETERY OR CREMATORY Sudlersville Cemetery.		23d. LOCATION (City or Town) (County) (State) Sudlersville, Q.A.Co; Md.	
24. FUNERAL DIRECTOR Edward Fellows & Son, Millington, Md. 21651		ADDRESS		25a. REC'D BY REGISTRAR JUN 17 1969	25b. REGISTRAR'S SIGNATURE William Judge

27.07.01

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DOI: 10.1002/for

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10112 • J. Neurosci., September 24, 2008 • 28(39):10107–10112

100-443887-100

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

08933

**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

08925

1. DECEASED-NAME (Type or Print) William Franklin O'Donnell			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> JUNE 29 1969			2b. HOUR 5:50 P.M.		
3. SEX Male	4. RACE White	5. DATE OF BIRTH July 4, 1910	6. AGE (in years) 58 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD JUNE 29 1969		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Queen Anne's		
10. CITY OR TOWN OF DEATH Near Grasonville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) xxx			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Waterman		12b. KIND OF BUSINESS OR INDUSTRY xx
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Queen Anne			13c. CITY OR TOWN Grasonville		13d. INSURE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
14. FATHER'S NAME Harry O'Donnell			15. MOTHER'S MAIDEN NAME Rilla Warner			13e. STREET AND NUMBER xxx		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes			16b. SOCIAL SECURITY NO. W.W. 2			17. INFORMANT ADDRESS Mrs. Muriel Lane-Stevensville, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Blood Loss 814.7 DUE TO, OR AS A CONSEQUENCE OF: Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Excimeration DUE TO, OR AS A CONSEQUENCE OF: (c) Fracture of Neck APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Walked in front of vehicle - fast lane		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Rt 96-301 Grasonville			21f. LOCATION Street or R.F.D. No. City or Town County State Grasonville QA Md		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE John R. Smith Jr.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED 7/2/69		
ADDRESS (Street, city, town, or county)			Centreville, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE July 2			23c. NAME OF CEMETERY OR CREMATORY Stevensville		
23d. LOCATION (City or Town) (County) (State) Stevensville, Q.A. Md.			25a. REC'D BY REGISTRAR JUL 7 1969			25b. REGISTRAR'S SIGNATURE Charles Judge		
24. FUNERAL DIRECTOR Alyce R. Lane			ADDRESS Church Hill, Md.					

08933

08933

UNITED STATES DEPARTMENT OF THE INTERIOR

Geological Survey

WATER RESOURCES DIVISION

WASHINGTON, D. C. 20242

OFFICE OF THE ASSISTANT ATTORNEY GENERAL

WASHINGTON, D. C. 20530

ATTENTION: LEGAL COUNSEL

TELEPHONE: 202-271-2000



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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08934

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

08926

1. DECEASED-NAME (Type or print) NEWTON (MACK) RYAN			2a. DATE OF DEATH Month June Day 28 Year 1969			2b. HOUR 8 A.M.			
3. SEX male		4. RACE white		5. DATE OF BIRTH July 5, 1890		6. AGE (In years last birthday) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Kent Co. Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Queen Anne Md.			
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) at home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired State Road Comm.		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland COUNTY Queen Anne		13b. CITY OR TOWN Chestertown		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Kingstown			
14. FATHER'S NAME First Middle Last Joseph Ryan				15. MOTHER'S MAIDEN NAME First Middle Last Margaret Berger					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no		16b. SOCIAL SECURITY NO. 219 36 6236		17. INFORMANT Mrs. Hazel Duff Address RFD Chestertown, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH several years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from May , 19 68 , to 6/28 , 19 69 , that (I) (we) last saw the deceased alive on 6/28 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Robert W. Farr				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6/28/69			
22d. PHYSICIAN'S NAME (Type) Robert W. Farr				22e. ADDRESS Chestertown, Md. 21620					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/30/69		23c. NAME OF CEMETERY OR CREMATORY Chester Cemetery		23d. LOCATION (City or Town) (County) (State) Chestertown, Md.			
24. FUNERAL DIRECTOR William Wells				ADDRESS Chestertown, Md.		25a. REC'D BY REGISTRAR DATE JUL 2 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

